Too many specialists, not enough GPs: Poland seeks change in wake of East Bloc collapse

Susan Thorne

Now that the Communist era has ended, Poland's medical community is confronting the heady task of reforming an inefficient and wasteful health care system that was long abused for political purposes. Numerous changes are being contemplated, but one idea that has general support is the development of a more broadly based education system that could produce family doctors based on the Western model. Just what sort of practitioners they will be, and how and where they will be educated, is the subject of much debate.

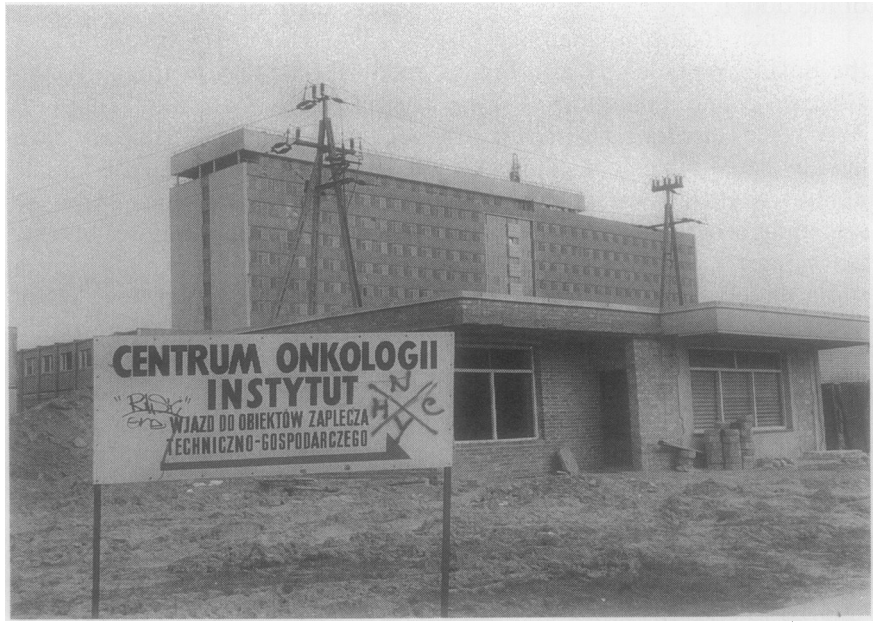
"Our medical system is sick," declares Dr. Janusz Szajewski, director of the Poison Control Unit at Warsaw's Szpital Praski and a member of the steering committee looking into national health care reform. He catalogues some of the worst problems: a cynical administration that has left the medical profession demoralized, duplication of services by parallel hospital systems, medically inappropriate use of hospital beds and the lack of an adequate national budget allotment for health care.

Susan Thorne is a freelance writer living in Kingston, Ont.

However, he says one of the most serious problems inherited from the country's Communist regime is the lack of good primary medical care. Primary care in the former East Bloc countries was patterned after the Soviet polyclinic system, in which local health centres offered a range of medical services provided by specialists. In smaller rural centres, the physicians on staff at the clinic would typically be an internist and pediatrician, with an obstetrician-gynecologist and surgeon or other specialists included at larger facilities.

Doctors were trained accordingly, and as a result 75% of Poland's 80 000 physicians — the doctor-patient ratio is roughly 1:500 — have specialist qualifications. The only education in general medicine is available through a program in Lublin that trains rural practitioners; it has produced a few thousand graduates.

As might be expected, there is an oversupply of personnel in some specialties. Also, the referral



Construction of this oncology clinic in Warsaw was halted more than a year ago

rate to secondary care is high: 31% of patient services are provided by secondary or tertiary care facilities, according to a 1991 study done for the World Health Organization — triple the rate in the UK. Szajewski says that a Pole with a particularly complex set of symptoms "could easily be treated by seven specialists — a diabetologist, a vascular specialist, a nephrologist, and so on — with different and completely separate documentation for each." He said there would be little or no communication among the consultants.

Medical education corresponds poorly with the demands many physicians will encounter in practice, says Szajewski. One-fifth of Polish medical graduates are employed in primary health care, where they become de facto GPs, unable to use much of their specialist training but poorly prepared for a varied caseload.

Recognizing such problems, the national medical reform steering committee, which comprises representatives from the medical schools, the Ministry of Health and the Chamber of Physicians (the Polish equivalent of the CMA), is eager to establish training in general or family medicine. The need for GPs is considered sufficiently urgent that the solution cannot wait until new graduates pass through the training pipeline; some practising doctors are also to be retrained to qualify them for general practice. Many of these potential recruits are practising specialist physicians, which makes this a very unusual project.

The project itself raises some difficult questions. What is a *lekarz rodzinny* (family doctor), and what elements of education must be added to specialty training to produce one? Who will instruct and train in this new discipline, and above all, how will funding be secured in financially strapped Poland?

Dr. Andrzej Sliwowski, head of a family medical clinic in central Warsaw, has a scheme that he hopes will be accepted. His plan is to give licensed physicians a 3-year postgraduate crash course in most of the major specialties, in order to acquire the basics of each one.

Under the plan, would-be GPs who had qualified as internists would receive supplementary training in areas such as anesthesiology, surgery, pediatrics and psychiatry to round out their education. The program content would vary to reflect the character of the student's medical practice — urban, small city or rural. A city GP, for instance, would be deemed to need less training in obstetrics, but should have more knowledge about AIDS and gerontology than a doctor in rural practice. Sliwowski also includes some course content in areas such as psychosocial issues, epidemiology and computerization, which transcend the specialty disciplines.

In all, the 8 or 10 turns of duty involved in the program would entail 930 hours of practical work and 200 hours of theory, and could be accomplished in three stints, each lasting 10 weeks. A final standardized government exam would qualify the physician for a licence.

Poland a growing market for private health care

Will Poland's new GPs go the way of dentists, who have become almost totally independent of the public health care system? "Look," says one Krakow physician, showing off his modern, well-appointed, downtown office. "In 3 or 4 hours per week of private practice here, I can earn as much as I do in my [full-time] work as a government health official."

Low salaries have long obliged many Polish doctors to supplement their earnings with a second job, usually through a private practice or part-time position at another facility. Physicians in the government-funded health service have average earnings of 1 million to 1.5 million zloty monthly — about $91 to $136 in Canadian funds. (The average monthly wage is about 2.5 million zloty, and there were 11 000 zloty to the Canadian dollar when this article was written.) One senior supervisor in a Warsaw hospital estimates that he could earn more as a sidewalk "entrepreneur," selling goods on the street.

Ninety percent of all health care services are still state financed, but the proportion of physicians in private practice has increased greatly in the last 3 years, to as much as 60% in some communities, says Andrzej Rhys, deputy director of the School of Public Health in Krakow. The private market is expanding rapidly to include pathology and even some surgical procedures, he says. In some areas, the private sector offers the most modern and efficient facilities as well as the most capable doctors.

Unemployment of medical graduates, a problem unknown until recently, may cause more physicians to go completely private. The "free" health market is abetted by the introduction of private medical insurance coverage by firms such as Westa Medical Life. In 1993, Western insurance firms will be allowed to invest in Poland.

Sliwowski's formula does not follow Western principles of family medicine, but he doesn't apologize for this — he maintains that Poland requires its own GP formula. "We don't need teachers from abroad, because they don't know the Polish medical system and its special problems," he says.

Sliwowski presents an academician's approach to medical reform, but a very different point of view is found at Ciechanow, a small city an hour north of Warsaw that has about 35 000 residents. The town is the seat of a health district recently selected for special World Bank assistance to enhance health care facilities. Rural poverty abounds in the surrounding countryside, where horse-drawn farm machinery is the norm. The regional hospital is painfully underequipped by North American standards, but it is well maintained and manned by a dedicated staff.

An interview with Drs. Michal Kornatowski, the hospital director, and Elwira Soplinska, the regional medical officer, makes it apparent why Ciechanow was considered a good candidate for aid. These key administrators radiate enthusiasm for improving health care and health promotion in their district, and look to Western medical practice for innovations. As senior pediatrician in the hospital, Soplinska has managed to significantly lower infant mortality and disease rates in the area through public education about breastfeeding and prenatal care. (In 1991, for the first time, the Ciechanow hospital allowed a father in the delivery room during a birth, something that's rarely done in Poland. "We are pioneers!" says a proud Soplinska.)

She and Kornatowski feel strongly that the training of family physicians should be rooted in the realities of daily practice, and acknowledge the rural environment that is home to 40% of Poles. They reject the idea of transplanting physicians to a city for extended periods of training. This is not only impractical in terms of a wage-earning physician's schedule, says Soplinska, but might also mean training with equipment that is unavailable outside of urban centres.

"Our staff could educate the doctors, our department chiefs could educate them," she stresses. "They know this work." She proposes a course of continuing education, possibly part-time classes accommodated within a physician's schedule, with subprograms according to each doctor's specialty and situation. Instruction in English reading skills would be needed, since little contemporary research is available in Polish.

Probably the most detailed blueprint for training Poland's future GPs is the one just published by the Family Doctor Task Force in Krakow, which has conducted extensive research into European systems of family medicine. This group takes a staunchly holistic view of the family physician's responsibilities, and says community and social activism to combat health problems are part of the GP's role. It defines a family doctor as "a competent physician able to secure basic and continuous care for individuals, families and the local community irrespective of age, sex and the type of illness."

The training work load is substantial: basic education in the 3-year undergraduate curriculum includes an annual practical component of at least 1200 hours, plus 240 to 480 hours of classes in theory. Dr. Adam Windak, head of the task force, says that most postgraduates are expected to come from the ranks of first-degree pediatricians and internists — those less highly trained than second-degree specialists. Their training and study will last 2 years.

It is possible that all three plans will be implemented to train family physicians, or that a hybrid combining all three will be developed. Uncertainty about the fragile Polish economy has to be a footnote to every discussion — austerity and cutbacks have become a reality in Polish health care. But $200 million in World Bank and European Economic Community support is partly earmarked for family physician development, so some progress is likely. "Of course we know it will be a long-term solution, over the next 15 to 20 years," Windak concedes.

There will probably be no shortage of candidates for the new training. Sliwowski is already receiving three applications for every space in his pilot course, and suggests that family practice skills may offer the physician a competitive advantage as health care in Poland becomes increasingly privatized.■

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